

## Appendix C: Opportunities for Maryland Investment in Care Coordination

Activity	State-level	Regional-level	Local-level	Implementation Strategy
<b>A. Build/secure a data infrastructure to facilitate identification of individuals who would benefit from care coordination. <u>High-level goal:</u> To secure, organize, synthesize, and share data that will support care coordination and enable more robust care management and monitoring.</b>				
1. <b>Develop procedures and policies to secure patient consent</b> for the sharing of data for purposes of care coordination.	X			1. <b>Use for BRFA funds:</b> Ask CRISP to develop three-part patient consent in standardized format.
2. <b>Combine existing data sources</b> for the purpose of identifying individuals who would benefit from care coordination.	X			2. <b>Use for BRFA funds:</b> Provide financial support to CRISP to create, for example, high-utilizer report from Hospital Case Mix and ENS data and attribute patients to PCPs.
3. <b>Secure new data sources.</b> Specifically, request the use of Medicare patient-level data for the purpose of identifying individuals who would benefit from care coordination and chronic care management.	X			3. MHA to coordinate hospitals to make a special request to CMS, in concert with the State, for access to Medicare data in this form and for this purpose. The theme is to “get it, organize it, synthesize it, and use it.”
4. <b>Engage CRISP to contract with a qualified vendor</b> to store, clean, and normalize the Medicare data and other Medicare-related data sets Maryland may be able to obtain.	X			4. Use BRFA funds to purchase capabilities from an existing qualified vendor.

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5. Use data to identify individuals who would benefit from care coordination and chronic care management; use alert mechanisms to connect these patients to the physicians and hospitals who care for them (e.g. alerts to PCPs when their patients are in the ED or admitted to the hospital. The alerts are set in motion by enrolling providers in the CRISP ENS system)	X			5. Use BRFA funds to secure contractor to convene leaders, community organizations, and patient advocates, in developing best possible approaches to stratifying patients, based on needs of hospitals and other providers; attribute patients; and store and view care profiles and HRAs.
<b>B. Encourage and support patient-centered care. High-level goal: Identify standard elements of care profiles that can be shared; propose future standards for the creation of Individualized Care Profiles.</b>				
1. Provide resources to design basic patient care profiles that are standardized and interoperable; make these profiles readily viewable across the continuum of care: Restated, care profiles should be “doable and viewable” after establishment, to facilitate implementation and monitor ongoing use.	X			1. Use BRFA funds: Create patient care profiles in standardized format. <ul style="list-style-type: none"> <li>• <b>First priority:</b> the approximately 40,000 highest-needs Medicare FFS patients.</li> <li>• <b>Second priority:</b> additional patients who would qualify for providers to get federal CM payments for care management, many of whom will also be included in the First Priority</li> </ul>
2. Standardize health risk assessment elements	X			2-3. Use BRFA Funds:

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3. Standardize elements in discharge summaries to aid transitions to long-term and post-acute care (LTPAC) providers as well as home-based settings.	X			Use BRFA funds to secure contractor to convene providers and create health risk assessments, and care profile elements; patient representatives (including health literacy experts) will be engaged in the process to ensure these profiles are readily understandable to the patient and their caregivers. The information in the profiles could be made available "along the highway" connecting different providers across a continuum of care.
4. Develop approach to identify patients with care plans through CRISP, together with identification of care managers and providers. Explore feasibility of CRISP providing a useful version of care plans, using a "whiteboard" attached to ADT files. Set up process for learning, monitoring, and managing the system to determine the effectiveness of this effort over time, and make needed adjustments.	X			4. Use BRFA funds to have CRISP create easily visualized access to care plan data elements. A care coordination team needs this information to help keep patients out of the hospital. These care coordinators should have information about social services as well as medical services that the patient may need and should have access to a catalogue of available medical, social service, and community-based resources.

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<b>C. Encourage and support patient engagement, decision-making and self-care.</b>				
1. Lead a state-level campaign to encourage individuals to 1) participate in care plans and 2) complete and share medical orders for life-sustaining treatment.	X			1. State and county health departments lead state-level campaign for engaging patients and families in care planning and consents, together with consumer groups (e.g., the HSCRC Consumer Engagement, Education and Outreach Task Force) and other stakeholders. Adequate funding for these entities is required for success. Clear and consistent messaging should be developed and used across the state.
2. Educate patients about care coordination resources and opportunities, and mobilize self-care. Giving patients appropriate and timely information is the key to patient activation.	X		X	2. Health departments can play a lead role in educating patients and convening local leaders; the HSCRC, consumer groups such as the Consumer Engagement, Education and Outreach Task Force, MHA, MedChi, and Health Departments can lead statewide education campaigns. Hospitals and physicians can help educate patients. In addition, patient self-activation is very important so that patients can become their own managers.
<b>D. Encourage collaboration.</b>				
1. Facilitate somatic and behavioral health integration.		X		1. <b>Use BRFA funds.</b> BRFA funds can provide financial support for planning approaches.
2. Facilitate care integration between hospitals and long-term care/ post-acute services	X			2. <b>Use BRFA funds.</b> Use BRFA funds to develop approaches to care integration that can be deployed on a regional and local level.

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3. Facilitate collaborative relationships among providers, patient advocates, public health agencies, faith-based initiatives and others with a particular focus on resource planning, resource coordination, and training.	X			3. Use BRFA funds to provide regional planning resources, including technical resources to support regional planning efforts. Make the DHMH web-based inventories of community services more exhaustive, up-to-date, and accessible across the State.
4. Develop processes to avoid duplication of resources across provider systems, including coordination of resources for health risk assessments.		X	X	4. Work with DHMH to create web-based inventories of community services available in the State. Use BRFA regional planning processes to avoid duplication of resources.
5. Support practice transformation through technical assistance and dissemination of information on best practices.	X			5. Funding source TBD.
6. Create standard gain sharing and pay for performance programs.	X			6. <b>Use BRFA funds:</b> Use BRFA funds to develop standard approaches to pay for performance and gain sharing opportunities in Maryland. Work in coordination with MHA approach for hospital-based services and the establishment of gain sharing programs between hospitals and ambulatory providers focused on high-risk patients.
7. Encourage providers to take advantage of new Medicare Chronic Care Management payments.	X			7. Funding source TBD.
<b>E. Connect providers.</b>				
1. Help CRISP promote the connection of community-based providers to CRISP.	X			1-4. Funding source TBD.
2. Help CRISP connect long-term and post-acute providers (LTPAC) to CRISP. Develop approaches to meet needs of LTPAC.	X			
3. Purchase/develop applications to facilitate interoperability among providers' EMRs to make clinically relevant information available to providers	X			

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4. Coordinate the effort to use Medicare data with initiatives to use EMR data, information on high-needs patients in Medicaid and private plans for population health and outcomes measurement.	X			
5. Encourage and support Regional Partnerships in their efforts to connect providers as they manage patients' care plans, monitor local service quality and supply, and engage local citizens and caregivers in shaping priorities.		X		5. Funding source TBD.